HINDS' FEET FARM INFECTIOUS & COMMUNICABLE DISEASE FORM

INFECTIOUS & COMMUNICABLE DISEASE FORM

For the protection of Hinds' Feet Farm (HFF) members, staff, community volunteers, student interns, and others, all participants and/or possible participants of Hinds' Feet Farm residential and day programs must attest to being free from any infectious or communicable disease, or the participant must inform Hinds' Feet Farm of which infectious/communicable disease they have. If a participant has an infectious/communicable disease, Hinds' Feet Farm will consult with the participant's doctor, HFF's Medical Director, and program staff to determine the participant's eligibility for program services.

Hinds' Feet Farm members, staff, community volunteers, student interns, and all others participating in residential and/or day programs who have contracted an infectious or communicable disease should refrain from reporting to work or participating in the programs until there is no risk of infecting others, and may be required to provide a signed note from a medical professional attesting to such.

All identified occurrence of infection exposure will be reportedly immediately to the Director and/or his/her designee so that the local Health Department can be notified for further instruction. An incident report will be completed. An investigation will occur into all incidents of infectious disease exposure. All findings will be reported to QA/QI committee for recommendations.

Hinds' Feet Farm members, staff, community volunteers, student interns, and all others participating at the day program will practice universal precautions and take other appropriate steps to prevent the spread of infectious and communicable diseases.

FOR OFFICE USE ONLY	
Member Name:	**DOB:**
HFF ID #:	
Medicaid ID #:	

By signing below, you attest that you are free from any infectious/communicable disease (such as but not limited to HIV/AIDS, Hepatitis, TB, etc.).

______________________________ ______________
Name & Signature **Date**

______________________________ ______________
Parent/Guardian's Name & Signature (if applicable) **Date**

______________________________ ______________
Hinds' Feet Farm Staff Name & Signature **Date**

By signing below, you are confidentially informing Hinds' Feet Farm that you have an infectious or communicable disease and you understand that HFF reserves the right to determine participation eligibility.

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Type of Infectious/Communicable Disease

______________________________ ______________
Name & Signature **Date**

______________________________ ______________
Parent/Guardian's Name & Signature (if applicable) **Date**

______________________________ ______________
Hinds' Feet Farm Staff Name & Signature **Date**

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Member Name:	**DOB:**
HFF ID #:	
Medicaid ID #:	